Dale B.Mortimer, M.D., P.C.
Physician
General Adult Psychiatry
Child & Adolescent Psychiatry
Diplomate, American Board of Psychiatry & Neurology

TELEHEALTH/TELEMEDICINE INFORMED CONSENT

I, _____ (name of patient) hereby consent to engaging in telehealth audio only medical/psychiatric services (also known as telephone consultations with Dale Mortimer, M.D.) as part of my medical/psychiatric treatment.

I understand that "telehealth or telemedicine" (also known as telephone consultations) includes the practice of health care delivery, assessment, diagnosis, consultation, treatment, transfer of medical data, and psychoeducation using interactive audio communications (also known as "using a telephone or cell phone").

I understand that, with my signed consent, telehealth may also involve the communication of my psychiatric/medical health information (orally) between Dr. Mortimer and/or his staff at the office of Dale B. Mortimer, M.D., P.C.

Technology: I understand that I will need a telephone, cell phone or satellite phone in order to make use of the telehealth/telemedicine services provided by Dr. Mortimer.

Location: I understand when participating in telehealth services with Dr. Mortimer that I must be at home or at a location appropriate and private enough for discussing medical/psychiatric concerns with Dr. Mortimer or his staff.

Financial Obligations: I understand that telehealth services are billed at the same rates as in–person care and my fee agreement applies to telehealth services. I understand that Washington State parity law mandates payment for medically necessary telehealth services at the same rates as in–person care under private insurance and state employee health plans. I understand that I am responsible for all fees not covered by my medical insurance company, including no–show fees.

Crisis Services: I understand that telemedicine appointments are considered outpatient medical/psychiatric services and are not intended as a substitute for emergency or crisis services. If I am experiencing a life–threatening medical/psychiatric emergency, I will either call 911, call my primary care physician, or present myself to the nearest hospital Emergency Services Department.

Video/Audio Recording: I understand that Dr. Mortimer will not record telehealth sessions (i.e., telephone or cell phone calls) without prior permission from me.

Confidentiality: The laws that protect the confidentiality of my personal medical information also apply to telehealth. As such, I understand that the information released by me during the course of my sessions is generally confidential. I also understand that there are both mandatory and permissive exceptions to confidentiality including but not limited to – reporting child and vulnerable adult abuse, expressed imminent harm to oneself or others, threats of violence, or as a part of legal proceedings where information is requested by a court of law. I also understand that the dissemination of information from the telehealth interaction to other entities shall not occur without my written consent.

I understand that I have the following rights with respect to telehealth services with Dr. Mortimer and his staff.:

1. I have the right to withdraw my consent to participate in telehealth services provided by Dr. Mortimer at any time.
2. I understand that there are risks and consequences associated with telehealth including – but not limited to – the possibility, despite reasonable efforts on the part of Dr. Mortimer and/or his staff that: the transmission of my personal medical/psychiatric information could be disrupted or distorted by technical failures and/or the transmission of my personal medical/psychiatric information could be interrupted or intercepted by unauthorized persons or agencies (e.g., Homeland Security, the NSA, CIA, FBI or other three–letter federal agencies).
3. I understand that I may benefit from telemedicine but that results cannot be guaranteed or assured. In addition, I understand that telehealth–based medical/psychiatric services (i.e., telephone consultation with Dr. Mortimer) and care may not be as complete or comprehensive as in–person medical/psychiatric services. I understand that if Dr. Mortimer believes that I would be better served by other medical/psychiatric interventions, then I may need to schedule an appointment to meet with Dr. Mortimer in his office. I also understand that there are potential risks and benefits associated with any form of psychiatric/medical treatment, and despite my efforts and the efforts of Dr. Mortimer, my medical/psychiatric condition may not improve – and may even worsen.
4. I understand that once the current national health emergency caused by the COVID–19 pandemic has resolved, then the Washington Medical Commission (or other State of Washington agency) might capriciously and arbitrarily decide to prohibit either: (1) Dr. Mortimer from continuing to provide telehealth services to me; or (2) my medical insurance carrier from reimbursing Dr. Mortimer for his telehealth services (i.e., telephone consultations with me) at parity with in–office medical/psychiatric care.
5. I understand that I have a right to access my medical/psychiatric health information and request copies of medial records in accordance with Washington state law.

By signing this document, I agree that certain situations – including medical/psychiatric emergencies and crises – are inappropriate for telehealth services. If I am in the midst of a medical/psychiatric crisis or emergency, I should immediately call 911, my primary care physician or go to the nearest hospital Emergency Department. I understand that emergency medical/psychiatric situations may include: thoughts about self–harm, thoughts about hurting others, having uncontrolled psychotic symptoms, being in a life–threatening or medical/psychiatric emergency situation, or experiencing an overwhelming, irrational desire to believe ostensible political flapdoodle promulgated by the mass media or the Internet.

I have read and understand the information provided above. I have discussed telehealth with Dr. Mortimer or his staff, and all of my questions have been answered to my satisfaction. My signature below indicates my informed and voluntary consent to medical/psychiatric treatment using this telehealth platform (i.e., telephone or cell phone communication with Dr. Mortimer or his staff).

_____ (patient signature) _____ (Date)